PSYCHIATRIC SEQUELAE OF RAPE - A HOSPITAL SAMPLE

BY

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CONTENTS

INTRODUCTION

Rape is recognised as the most rapidly increasing reported violent crime in the United States of America (Gise, 1988). Rape in South Africa is also rapidly increasing (The Argus, September 3, 1992).

In South African law, there are two forms of rape, statutory rape and forcible rape. Statutory rape applies to the action of one who engages in sexual intercourse with a female under the age of consent (16 years) even if she participates willingly (Criminal Procedures Act 1975).

Forcible rape "consists in a man having unlawful and intentional sexual intercourse with a female without her consent". Intercourse is further defined as "any degree of penetration by the male genital organ into the women's vulva or labia."

In the United States of America, (U.S.A.) rape is defined as "carnal knowledge of a person by force and against her will". Two elements are necessary to constitute rape (a) sexual intercourse and (b) commission of the act forcibly and without consent. The slightest penetration by the male organ constitutes carnal knowledge and neither complete penetration nor emission is required.

In both South Africa and the U.S.A., the legal definition has shortcomings. These are:

a) Rape within marriage is excluded.

b) Rape by women on men and men on men is excluded.

c) Other acts such as oral and anal penetration, or the use of objects for penetration is excluded.

d) the burden of proof is placed on the female

Incidence of Rape

All rape statistics must take into consideration the large number of rape incidents that go unreported. Rabkin (1979), in the U.S.A. reported that characteristics of the offender, of the act and of the victim-offender relationship influenced the reporting of the rape. Probability of reporting seemed enhanced when there was a greater age disparity between the offender and the victim, when the victim was injured, when there were witnesses, when the offence was inter-racial and when the offender was a stranger.

In the U.S.A. in 1985, when unreported cases were considered, it was estimated that one in three women would be raped in her lifetime (Gise 1988). South African statistics have rapidly approached and overtaken that of the U.S.A. Recent statistics showed that one in two women in South Africa could be raped in her life-time (Weekly Mail 6 - 12 September 1991).

Rape Sequelae

Study of the psychological effects of rape only begin in the 1970's (in the U.S.A.) with the Women's movement. In their seminal study, Burgess and Holmstrom in the U.S.A. (1974) analysed the effects of forcible rape in a sample of adult women.

They assessed the women immediately after the rape and at follow-up. Based on the analysis of the post-rape symptoms, they documented the existence of the "rape trauma syndrome". This syndrome had behavioural, somatic and psychological components. There were two phases - an acute phase, that occurred as a result of the disorganisation following the rape, and a reorganisation phase. The latter was influenced by ego strength, the social support network and being regarded as a victim. Symptoms varied from minimal to severe with rape-related nightmares, fears and sexual problems being common.

Burge (1988), studied the psychological symptoms in rape victims from Chicago and Okla in the U.S.A. The results of this study, combined with a review of the professional literature on rape, showed evidence of each of the criteria for Post Traumatic Stress Disorder (PTSD). She thus proposed that PTSD be used as an alternative to 'rape trauma syndrome' to reflect the awareness that the effects of exposure to a severely stressful event such as rape may persist for many years, and also confirm it as one of the many stressful experiences that humans are subject to.

Rape as a catastrophic event had been linked in the official psychiatric classification to a specific syndrome, that of PTSD. The core features (as defined in the DSM III and its revision DSM III - R) are:

i) A distressing event that is outside the range of usual human experience.

ii) Re-experiencing the trauma in nightmares, intrusive thoughts or flashbacks (dissociative episodes).

iii) Numbing of responsiveness or avoidance of thoughts or acts related to the trauma.

iv) Persistent symptoms of increased arousal.

The diagnosis of PTSD requires the persistence of symptoms for at least one month.

The first category of symptoms is the re-experiencing of the traumatic episode which may occur in a variety of ways. Individuals may suffer painful and intrusive recollections of the experience, nightmares or flashbacks (where the victim reacts behaviourally to the event she is reliving and not to actual circumstances). Burgess and Holmstrom (1979), Nadelson et al. (1982) and Burge (1988) have all observed intrusive thoughts as well as nightmares in victims of rape. A few researchers (Burgess and Holmstrom, 1979; Ellis et al., 1981; Nadelson et al, 1982) have reported the occurrence of flashbacks in their samples of victims. These flashbacks often occur during sexual activity, where a woman may feel as though her present partner is actually the rapist.

Diminished or restrictive responsiveness, otherwise known as "psychic numbing", is the second major symptom of PTSD. DSM III - R states that victims may feel detached or estranged from other people, or they may lose interest in significant activities that they previously enjoyed. In addition, emotions such as intimacy, tenderness, and sexuality may decrease markedly. Burgess and Holmstrom (1979) note that some rape victims may be observed to withdraw from people, life events and the world.

A few rape victims may discontinue their usual activities and become substantially immobile (Burgess and Holmstrom, 1979; Ellis et al, 1981). Others continue some activities but achieve only a minimal level of functioning (Burgess and Holmstrom, 1979). Ellis et al. (1981) reported that their sample of rape victims continued many of their activities, but reported less enjoyment and satisfaction with these activities. Fatigue and lack of energy have also been noted in rape victims (Burgess and Holmstrom, 1979; Ellis et al 1981). Women have been observed to detach themselves from others, and to suppress emotions following sexual assault (Nadelson et al., 1982). Sexual dysfunctions and disturbances in the victims' sexual patterns are common, and may result either from decreased affect or from dread of intrusive memories during sexual activity (Burgess and Holmstrom, 1979; Ellis et al 1981; Norris and Feldman-Summers, 1981; Becker et al., 1984).

The third category of symptoms is that of persistent arousal. Burgess and Holmstrom (1979) observed that rape victims, because of the intense fear that they experience following the assault, are easily startled or "jumpy". In Ellis et al's (1981) study of 27 rape victims, virtually all victims reported nightmares and sleeplessness. Nadelson et al. (1982) noted that the most common sleeping problems were nightmares and/or waking at night with an inability to fall back to sleep. Other researchers have also noted disruptions in the sleep patterns of rape victims (Burgess and Holmstrom, 1979; Norris and Feldman-Summers, 1981). Women who have been attacked in their own beds are particularly plagued by insomnia (Ellis, 1988).

The incidence of PTSD after rape is high and ranges from 70 - 86% (Burge, 1985; Frank and Anderson, 1987; Bownes et al., 1991; Breslau et al., 1991). Both Burge (1985) and Frank and Anderson (1987) studied rape victims who sought help from a crisis counselling agency in the U.S.A. Bownes et al. (1991) had a study population of rape victims in Northern Ireland who had sought compensation under the Criminal Injuries (Northern Ireland) Order. Breslau et al., (1991) studied a random sample of 1007 young adults from a large health maintenance organisation in the Detroit (Michigan) area of the U.S.A. to ascertain the prevalence of PTSD. They found that the incidence was 80% in women who reported that they had been raped. These studies also demonstrated that there was no significant relationship between the time that had elapsed since the assault and the symptomatology. The investigators also found that, in some victims, rape-related symptoms may persist for many years.

However, while not all women have the full PTSD response, all have definite symptoms immediately after rape e.g. increased anxiety, fear and mood disturbance (Burgess and Holmstrom, 1974; Kilpatrick et al., 1979). There tends to be a tapering of symptoms after three months in the majority of patients and by 1 year, 20 - 25% of victims were relatively symptom free (Kilpatrick et al., 1979). Recovery had been influenced by:

a) Absence of prior victimization
b) Absence of a chronic life stressor e.g. unemployment, social problems and lack of social support
c) Absence of past mental health problems (Burgess and Holmstrom, 1979; Norris and Feldman-Summers, 1981; Ruck and Leon, 1983; Cohen and Roth, 1987; Davis and Brickman, 1991)

These variables will be further analysed in the discussion.

However, for the majority of women, the trauma and events following it are so severe as to cause chronic symptoms. It will be some of these women who are likely to present for psychiatric treatment.

THESIS RATIONALE

It is therefore important to identify the characteristics of this group (above-mentioned) so as to streamline treatment strategies. The medical literature contains no readily available reports about either the profile of hospitalized rape victims, or their treatment. As all the research has been done on out-patient populations, the extent to which these findings may be applied to a hospital sample, may be questioned. This pilot study aims to identify common factors and significant variables in a group of hospitalized rape victims (i.e. victims whose symptomatology had been too severe to be alleviated in an outpatient setting). In seeking out the common features in this group of traumatized victims, it is hoped to gain a better understanding of their particular vulnerability to severe psychic trauma. This could aid in the earlier detection of high risk victims and help to streamline quicker referral for treatment. Earlier psychiatric treatment may help to prevent the persistence of chronic symptoms and help the victims to deal more effectively with their trauma.

METHODOLOGY

The records of all female patients admitted over 2½ years to a psychiatric ward at Lentegeur hospital[1] were examined. This ward admits apsychotic patients, whose main presenting symptom is depression due to bereavement, family and marital problems or rape. Treatment is based on therapeutic community principles and group therapy. Family, individual and hypnotherapy are used where indicated.

All the records (381) were scrutinized and those patients, whose reason for referral or presenting problems were rape-related (as understood by the patient), were included in the study. Only victims of completed rape were included. Excluded were victims of attempted rape (2) and those who had a history of rape but whose presenting problems were not rape-related.

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[1] Lentegeur Psychiatric Hospital was established by the South African government as part of its apartheid policy to establish facilities for the population based on racial classification (as part of the separate development programme). The hospital is situated in Mitchells Plain - an area designated for the housing of "coloured" people (Group Areas Act 1950). Initially only "coloureds and asians" were admitted although the hospital was open to all races. It is a public facility admitting all psychiatric patients in need of hospitalization. Hospital fees are charged on a sliding scale, according to income. Those patients who have medical aid insurance or are in the high income bracket are charged fees equivalent to that charged by private hospitals.

The sample consisted of twenty-two patients. However, one patient's folder was lost and another discharged herself very soon after admission. The study sample thus consisted of 20 patients. The records for each patient were examined. These records included a full psychiatric history and examination, examination of mental state, a detailed list of all symptoms reported since the assault, their time of onset and duration, and any treatment received. The records were examined for details of personal life, family and social support and clinical diagnosis (using DSM III - R criteria).

Specifically documented was:-

1) The experience of rape [modified for Renshaw's Rape History Flow Sheet (1989) {Appendix 1}].

2) Post rape symptoms - divided into
   a) Social deterioration.
   b) PTSD symptoms.
   c) Anxiety symptoms.
   d) Depressive symptoms.
   These subdivisions were necessary for data analysis.

3) Referral agency.

4) Past history of rape.

5) Past psychiatric history.

6) Length of hospitalization.

7) Presence of an emotional support network.

8) Need for medication, type of medication and dosage.

9) Type of therapy received.

10) Follow-up plans.

11) Evaluation of treatment via postal or telephonic contact (Appendix 2).

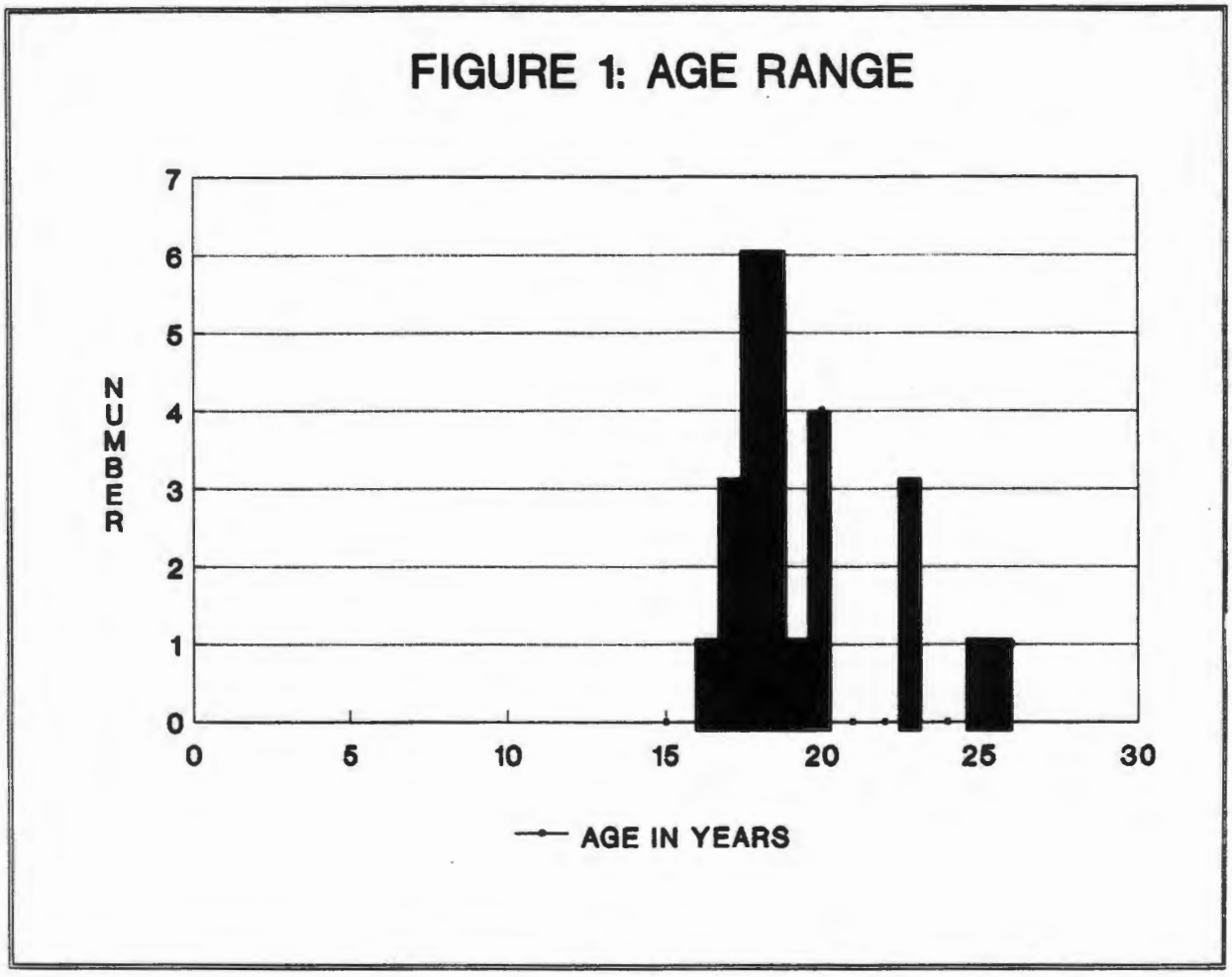
12) Summaries of each patient's record - (intended to highlight the rape situation and presenting symptoms) [Appendix 3].

The data collected was subjected to statistical analysis (as indicated in the text).

RESULTS

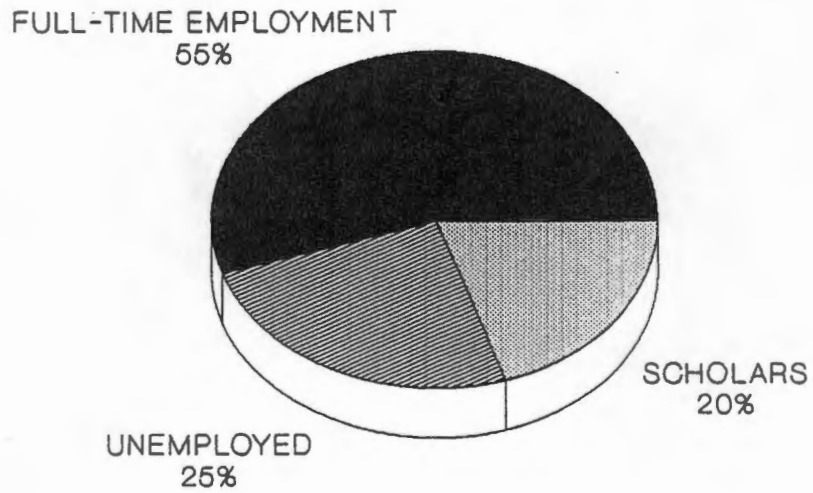
Demographic Data

The study population (20) comprised only single "coloured" women. The mean age was 19.7 years with a range of 16 to 26 (Figure 1). These women lived in areas previously reserved for "coloureds". (Although the Group Areas Act [1950] has been abolished, most of the population have remained in these areas because they do not have the financial resources to buy or rent accommodation in areas previously reserved for "whites".)



55% of the sample were in full-time employment with 25% unemployed. Scholars accounted for the remaining 20% (Figure II).

FIGURE 11: EMPLOYMENT STATUS



The Rape Situation

Specific details regarding the rape episodes were not recorded in all patients. This data (on the use of force, weapons and injuries sustained), could therefore not be analysed.

Single assailant attacks occurred in 10 victims (50%). 9 victims (45%) were raped by more than one assailant. One victim had been rendered unconscious and could give no account of her assault.

Attacks by strangers occurred in 10 victims with 9 being attacked by men known to them. The unconscious victim could give no account of her assailant.

The assault was reported to the police by 17 of the victims (85%). The remaining 3 declined to press charges. There was one prosecution (at the time of discharge from hospital), three acquittals and the remainder were pending.

Referral Agencies

The referrals were predominantly from psychiatric out-patient and emergency services (75%) followed by community resources 20% and general hospitals 5% (Figure III).

In 50% of victims, the reason for referral was suicidal risk. This was followed by requests for rape trauma management (30%), social deterioration (10%), depression and treatment failure by referral agency (5%) each - Figure IV.

FIGURE 111: REFERRAL SOURCES

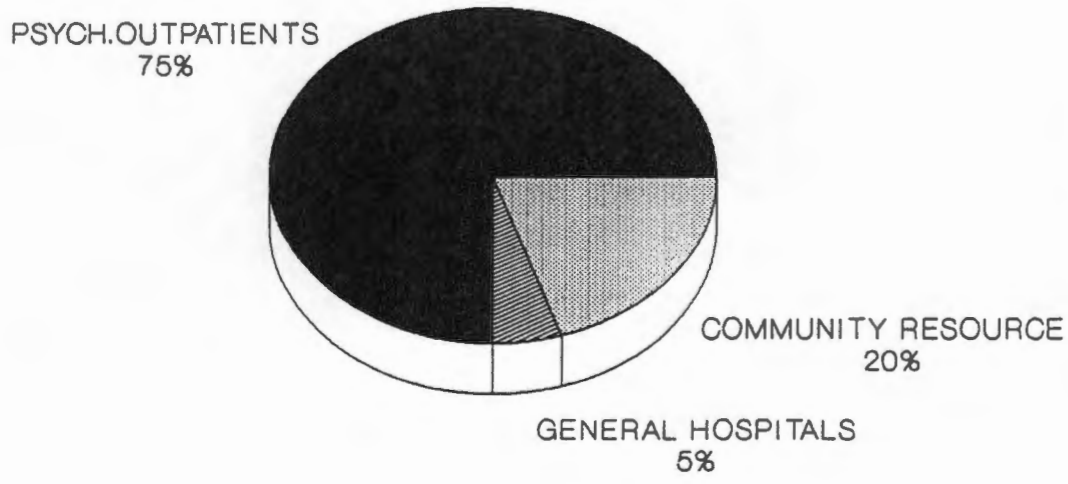
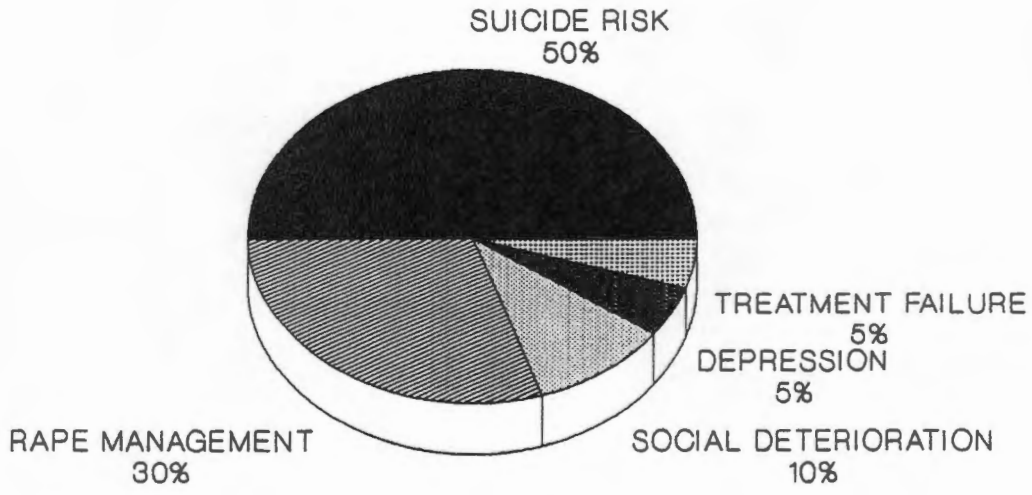


FIGURE IV : REFERRAL REASON



The Hospitalization

All the patients presented with symptoms of depression (100%) in combination with symptoms of:-

(A) Social deterioration - 5 patients (25%)

(B) P.T.S.D - 13 patients (65%)

(C) Anxiety - 8 patients (40%)

Table I demonstrates that the patients presented with more than 1 symptom.

TABLE I

REC	(A) SOCIAL DETERIORATION	B) PTSD SYMPTOMS	(C) ANXIETY	(D) DEPRESSION
1	N	Y	Y	Y
2	N	Y	N	Y
3	N	Y	Y	Y
4	N	N	N	Y
5	N	N	N	Y
6	N	N	N	Y
7	Y	Y	Y	Y
8	N	N	N	Y
9	N	N	Y	Y
10	N	Y	Y	Y
11	N	Y	Y	Y
12	N	Y	N	Y
13	Y	Y	N	Y
14	Y	Y	N	Y
15	N	N	Y	Y
16	N	Y	N	Y
17	N	N	N	Y
18	Y	Y	Y	Y
19	Y	Y	N	Y
20	N	Y	N	Y

(N = No : Y = Yes)

The period between the rape and hospitalization varied (Table II), with the mean period being 257,55 days.

TABLE II: PERIOD BETWEEN RAPE AND HOSPITALIZATION

	Immediate	Short-Term	Intermediate	Long-Term
Time between rape and hospitalization	0 - 3 months	3 - 4 months	4 - 12 months	>1 year
Number of patients	11	0	3	6

There was no relationship between the presenting symptoms and the period between the rape and hospitalization.

The mean period of hospitalization was 49.9 days. The nine patients who had a good support network spent a mean of 32.33 days in hospital, whereas the 11 unsupported patients spent a mean of 64.27 days in hospital. This is statistically significant with p = <0,05 (test of significance was the Mann-Whitney or Wilicoxon Two-Sample Test).

Scholars had the shortest period of hospitalization (25 days) with the unemployed being hospitalized for the longest period of time (mean 69.8 days) - Table III.

TABLE III: EMPLOYMENT STATUS VS MEAN PERIODS OF HOSPITALIZATION

	Scholars	Employed	Unemployed
Mean period of hospitalization	25 days	49.9 days	69.8 days

Although not of statistical significance, there is a tendency for the unemployed to need longer periods of hospitalization (p = 0,11 : Bartlett's Chi Squared Test)

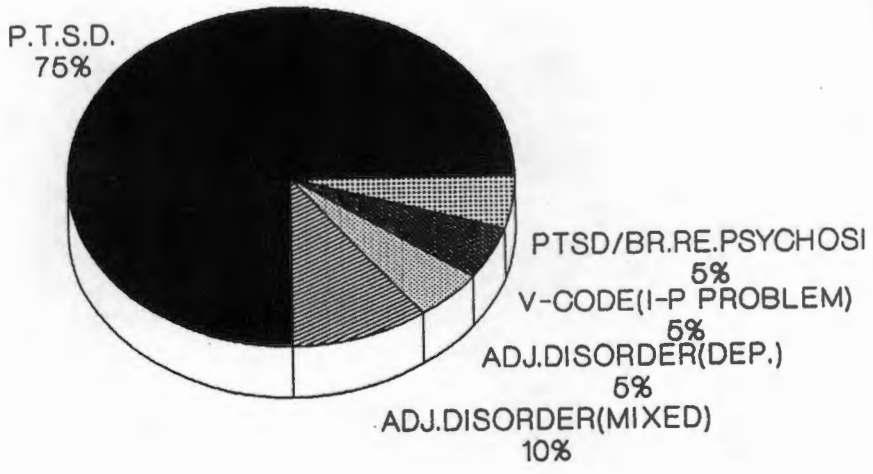
Seven patients had been raped before. There was no statistical significant relationship between these victims and the duration of hospitalization.

Only 4 patients were involved in a relationship at the time of hospitalization. 13 patients were not involved in any relationship. This information was not available in the records of 3 patients.

Two patients (10%) had a history of previous mental health problems.

The predominant diagnosis at discharge was PTSD (75%) as demonstrated in Figure V.

FIGURE V : FINAL DIAGNOSIS



All the patients received group, milieu and occupational therapy (including assertiveness training, social skills, role play and relaxation exercises). Some received additional family therapy, individual therapy or hypnotherapy. See Table IV.

TABLE IV: THERAPEUTIC INTERVENTION

Therapy Type	Group	Family	Individual	Hypnotherapy
No. of patients	20	6	8	5
Percentage	100%	30%	40%	25%

Only 3 patients received medication - two received amitriptyline for PTSD and one received trifluoperazine for her Brief Reactive Psychosis superimposed on PTSD.

Five patients needed rehospitalization. These patients had all not been supported by their families during their initial and subsequent hospitalization. The relationship between rehospitalization and non-supportive social network is significant with p = 0,0379 (Fisher 2-tailed Test).

An evaluation of the impact of the hospitalization was not possible due to the poor response to feedback requests. Only six patients responded to attempts at making contact with them. Of these, 4 reported no post rape symptoms. They felt that they had benefited from hospitalization. Two reported no benefit from hospitalization.

DISCUSSION

Limitations

This pilot study is limited by the small sample size, its retrospective nature and the lack of standardized instruments in assessment. Because of the absence in the medical literature of reports on a hospitalized group of rape victims, the results could not be examined in the light of previous studies. Additional problems are the lack of a control group and the fact that the sample is not representative of all rape victims as there are only single "coloured" women in the present study. However, the programme in the ward had developed in response to the increasing numbers of rape victims that were referred for in-patient management and despite the limitations of this study, certain themes do emerge that warrant report.

Age of Victims

The sample consisted only of young single women. Although women of all ages are at risk of rape, young women are at particularly high risk (Amir, 1971) and this is reflected in the study sample. Furthermore, other factors (to be discussed later) may compound in this high risk group and make them more vulnerable to the psychological consequences of rape for which they may need hospitalization.

Relationship to Rapists

Attacks by strangers occurred in only half the sample. This contradicts the myth that rapists are always strangers.

Burgess and Holmstrom (1979) reported that victims of confidence rapes (where the rapist was a boyfriend or male acquaintance) took longer to recover. Ellis et al. (1981) also reported that victims of attacks by complete strangers showed significant levels of depression on the Beck Depression Inventory as compared to none in non-stranger rapes. Santiago et al. (1985) in contrast found no significant relationship between stranger rape and post rape psychological symptoms. The reason for these conflicting results could be due to different populations studied, different instruments and different measures of victim outcome being used. In the present study, no significant relationship was found between stranger rape and presenting symptoms. There was also no relationship with the period of hospitalization.

Single vs Multiple Rapists

The percentages of the victims of single (50%) vs multiple rapists (45%) are similar to that found by Amir (1971) and Vogelman (1990). Amir's (1971) study of rapists revealed that close to 43% of rape cases involved 2 or more offenders. Vogelman's (1991) local study of rapists revealed that almost 45% of rapists had engaged in gang rape.

Rape Motives

Groth, Burgess and Holmstrom (1977) analysed accounts (both of victims and offenders) in an attempt to find motives for rape. They concluded that all cases of forcible rape had the components of power, anger and sexuality.

Power and anger would dominate and rape would be used to express these issues, rather than being an expression of sexual desire. In the power rape, the offender seeks power and control over his victim via intimidation using a weapon, physical force or threat of bodily harm. Physical aggression is used to overpower and subdue the victim and is directed towards achieving submission. The aim of the assault is usually to effect sexual intercourse as evidence of conquest. The victim is often kidnapped, tied up or otherwise rendered helpless. An example of this is patient number 3 who was threatened with a gun by someone posing as a detective. She was forced to accompany him to a deserted spot where he raped her.

In the anger rape, the offender expresses anger, rage, contempt and hatred for his victim by beating her, sexually assaulting her and forcing her to perform or submit to additional degrading acts. He uses more force than would be necessary to subdue his victim. The assault is one of physical violence to all parts of the body. The rapist often approaches his victim by striking and beating her, tears her clothing and uses profane and abusive language. This type of rapist aims to vent his rage on the victim and retaliate for perceived wrongs or rejections suffered by him at the hands of women. Sex becomes the weapon and rape the means by which he can use this weapon to hurt and degrade his victim. This is demonstrated by the vicious assault on patient number 18. Her assailant assaulted her, cut her clothes from her and raped her on her mother's bed. After he raped her he sliced at her breasts with scissors.

In contrast to the single assailant rape, in group or gang-rape, there is ritualized behaviour wherein emphasis is placed on the group and their expression of camaraderie with each other. The males interact primarily with each other and the victim is the vehicle for their interaction (Burgess and Holmstrom, 1980; Vogelman, 1990). The experience of patient number 11 demonstrates this point. She was raped repeatedly by her previous boyfriend and his friends. They took turns to rape her with the others holding her down. Once all four had raped her, they laughed together. After raping her they undressed her completely. When she sat naked before them, they laughed at her again.

Police Reports

It has been the experience in South Africa, the U.S.A and the U.K. that large numbers of rape incidents are unreported. Rape Crisis, a local counselling agency, estimates that only 1 in 20 rape incidents is reported. The reporting of rape is influenced by characteristics of the offender, of the act, of the victim and of the victim-offender relationship (Rabkin, 1979). Probability of reporting seemed enhanced when there was a greater age disparity between the offender and the victim, when the victim is injured, when there are witnesses, when the offence is inter-racial and when the offender is not previously known to the victim. Taking the above factors into consideration, it was surprising to find that 17 of the 20 patients had reported their rape experience to the police. This may well be attributed to the characteristics of this particular hospital sample as their post rape symptoms may have been more severe.

Despite the increased incidence of reporting, only 1 conviction had occurred with 3 rapists being acquitted. The remaining cases were still pending at the time of discharge from the hospital. These results are in keeping with the general experience i.e. that it is very difficult to secure a conviction, as the burden of proof lies with the victim. She has to demonstrate that intercourse had taken place without her consent. This is especially difficult with non-stranger and date rape. Ultimately only 50 - 55% of prosecutions lead to convictions in South Africa (Vogelman, 1990).

The Hospital Referral

The main reason for referral by the referral agencies (predominantly local psychiatric emergency and out-patient services), was suicidal risk. Some of these patients had already made a suicide attempt either by cutting their wrists or taking an overdose of medication, while others indicated that they intended doing so. Burgess and Holmstrom (1974), briefly mentioned that a particular group of victims in their sample, who had either a past history of physical, psychiatric or social difficulties along with the rape trauma syndrome, developed additional symptoms such as suicidal behaviour. Such victims needed more intensive intervention and were referred to other therapists. Greenspan and Samuel (1989) also reported on three patients in a general psychiatric unit in Philadelphia, U.S.A. who had cut themselves superficially: only when a detailed history had been taken did they discover that these patients had been raped.

Besides these two reports in the literature, suicidal ideation or attempts had not been mentioned as a specific symptom after rape. It is possible that, because of the age distribution of this sample (a predominant adolescent bias), adolescents are particularly vulnerable to acting out behaviour. Adolescents may therefore be at high risk for suicide and their needs in rape counselling may be different from that of their adult counterparts.

Thirty percent of the sample had been referred for in-patient rape-trauma management, since it was felt by members of the referral agency that these patients could not be managed on an out-patient basis. There have been no readily available reports in the medical literature on the in-patient management of rape victims. Moreover, most of the research has been done in the U.S.A. where there is an extensive self-help supportive infrastructure for rape victims. It is therefore likely that this helps the rape victim to remain in the community. South Africa has Rape Crisis Counselling Centres but they have been plagued by lack of funds and insufficient volunteers. Because of these problems, the local counselling network does not match that of the U.S.A. In addition, there is only one Rape Crisis Centre in Cape Town and clients have to use their own or public transport to reach the centre. Thus many socially disadvantaged victims who live on the periphery of Cape Town cannot avail themselves of these services.

Rape Sequelae

The post rape period has been defined empirically as:

a) Immediate reactions, occurring from 0 to 3 months after the assault
b) Short-term reactions, occurring from 3 to 4 months after the assault
c) Intermediate reactions, occurring from 4 months to 1 year after the assault
d) Long-term reactions, occurring more than 1 year after the assault

Researchers in the U.S.A. (Burgess and Holmstrom, 1974; Kilpatrick et al., 1979; Wirtz and Harrel, 1987) and U.K. (Mezey and Taylor, 1988) agree that rape victims experience anxiety, fear, mood disturbances and disruptions of sexual activity immediately after rape. Rape victims in Pittsburgh, U.S.A. were also more likely to meet criteria for major depressive disorder, generalized anxiety disorder, drug abuse and PTSD as compared with non-victimized control groups (Frank and Anderson, 1987).

By 3 to 4 months after the assault, rape victims' distress tended to improve in the majority of patients (Kilpatrick et al., 1979; Kilpatrick et al., 1981; Mezey and Taylor, 1988).

In the 4 months to 1 year period, rape victims had regained their psychological equilibrium but continued to have high levels of fears, phobic anxiety and panic attacks (Kilpatrick et al., 1979).

Sexual dysfunction had also been reported to be a problem. Women in Burgess and Holmstrom's (1979) sample had been completely abstinent from sex for at least six months after the rape.

There have been few studies documenting the effects of rape in the long-term. This has been partially due to difficulty in maintaining contact with rape victims as they often move, change jobs and fail to keep follow-up appointments, probably out of feelings of shame or reluctance to open old wounds.

In one study, rape victims interviewed after 1 year were significantly more anxious, fearful, suspicious and confused than the non-victim control group (Kilpatrick et al., 1981). These researchers did emphasize that, while most victims have rape-related problems after 1 year, not all do so. Between 20% and 25% of untreated victims were relatively symptom free, and paradoxically some victims reported better functioning at this time than they had been before the rape (Kilpatrick et al., 1981; Nadelson et al., 1982). This reinforces the view that for some people stressful life events - no matter how grim can foster maturation. However, this positive response to a major life stressor is dependent on previous life experience and adaptive capacity (DSM III - R, 1987) and therapy.

Ellis et al. (1981) found that rape victims were significantly more depressed than non-victim controls (who matched the victims on age, race, socioeconomic level and marital status) after 1 year. Nadelson et al. (1982) reported on specific symptoms (in 41 women) which occurred 1 to 2½ years after the rape. The symptoms (in decreasing order of frequency) were:

a)	Pervasive suspiciousness of others	76%
b)	Restricted going out	61%
c)	Sexual difficulties	51%
d)	Fear of being alone	49%
e)	Depression	41%
f)	Fatigue	39%
g)	Sleep disturbances	24%
h)	Lack of concentration	24%

In a controlled study, Santiago et al. (1985) in Arizona, U.S.A. used standardized instruments ot assess rape victims in order to determine the long-term effects of sexual assault. Rape victims were found to be significantly more depressed and fearful than control subjects (matched for age, ethnicity, marital status, employment status, education, family income, primary work role, living arrangements and past psychiatric history), irrespective of the number of years that had passed since the rape.

Patients in the local study sample were admitted to hospital at different intervals after the rape, thus falling into the immediate, intermediate and long-term groups. There were no symptoms specific to any one group. Many patients had varying combinations of symptoms i.e. of depression, post traumatic stress disorder, anxiety and social deterioration (Table I).

All patients had symptoms of depression. Post Traumatic Stress Disorder symptoms were present in 65% of the sample on admission with symptoms of anxiety and social deterioration occurring in 40% and 25% respectively. These symptoms were in keeping with that reported in the literature. The only difference between the study population and the populations reported on in the literature was the high level of distress which required hospitalization.

The following are extracts of letters written by three patients during their hospitalization (Appendix 4).

> "I weep every day because I am mourning - I have died and lost myself mentally. In the past I was an extrovert and looked at life with a positive eye. I could take failure and success and believed in myself. My experience (rape) had shattered my whole self-image, my trust turned into distrust and my love and caring attitude turned into hatred. My self-confidence turned into uncertainty, and I am feeling scared and afraid of what the future might hold for me - that's if there is a future in this dark cruel world for me at all".

> "I have certain feelings which I don't understand but I know these are the feelings that put me down. I wish I can escape this cause thing I know are that a knife wound won't hurt so bad as this hurt. At this very moment I feel like screaming, I'm frustrated.

Each time I ask myself, why me and keeping saying whether I'm right or wrong, I blame myself, I laid there allowing him to rape me. While I laid there anger grew strong deep inside of me. I feel like crying now but I can't, I'm too scared - I'm scared to let go of myself".

"Will I ever be able to go on with my life - I don't even care how I look or what other people say or do - I just feel like ending it all? Will the nightmares stop, will the guilty feeling that I have ever go away? Will I ever be myself again? Will I ever be able to use public transport again - do my own shopping and without being scared? I don't even think that I have a future. I am scared to sleep - sometimes I feel so empty that I get scared. I cry every day because I feel that I do not get answers".

Most patients (13) were not involved in any relationship at the time of hospitalization. This may have been related to the rape experience. Ellis et al. (1981) reported that many victims in their sample had been uneasy with men, not trusting them, and avoiding intimacy with them. Some had avoided dating after the assault for a period of several months to 5 years afterwards.

As most patients were not involved in any relationship at the time of hospitalization, an assessment of current sexual functioning could not be done. Sexual difficulties after rape have been reported as a long-term consequence of rape (Miller et al., 1982), with figures varying from 71% (Burgess and Holmstrom, 1979) to 51% (Nadelson et al., 1982); Becker et al., 1982). The most common problems were fear of sex with resultant avoidance and lack of desire or arousal. Sexual activity may also trigger flashbacks of the rape situation (Burgess and Holmstrom, 1979). These problems were not spontaneously volunteered by the rape victim but were easily elicited by direct questioning (Nadelson et al., 1982). This is of particular significance to counsellors in the holistic management of the rape victim.

Many patients, during their stay in the ward, indicated that they felt responsible for the rape and had guilt feelings as the result. Often their families or important people in their lives had accused them of being responsible for being raped. These attitudes compounded the feelings of responsibility and guilt. These may arise because of misconceptions and myths about rape that prevail in society. Myths about rape include the following (Gise et al., 1988):

1. All women want to be raped.
2. No woman can be raped against her will.
3. She was asking for it.
4. If you are going to be raped you might as well relax and enjoy it.

5. Rapists are strangers.
6. Rape occurs on the street.
7. Women are raped because they ask for it by dressing seductively or walking provocatively.
8. Only women with bad reputations are raped.
9. Only women in the lower social class get raped.
10. Most victims have been in trouble with the law in the past.

It has been suggested that the above-mentioned myths have not died out because of the attitude of society towards women's sexuality. A good woman is regarded as chaste. For her, rape is a fate worse than death and therefore she would fight to the death to avoid it.

Researchers have analysed many variables influencing the recovery of rape victims in an attempt to identify those at risk of long-term sequelae. In the present study, the patients who were unsupported, i.e. who received no emotional support from family, partner or close friends, spent almost twice as long in hospital (64,27 days) compared with those who were supported (32,33). This implies that patients who were supported recovered more quickly than those who were not. This is in keeping with the literature (dealing with out-patient samples) of rape victims who had lacked social support (Burgess and Holmstrom, 1979; Norris and Feldman-Summers, 1981; Ruch and Leon, 1983; Davis and Brickman, 1991). When married victims were compared with single victims, lack of support by the partner, particularly when it was unexpected, was significantly related to poor psychological functioning after the rape (Moss et al., 1990).

Of significance also, was the fact that all 5 patients needing rehospitalization had not been supported by their families. This once again highlights the importance of emotional support in the recovery of rape victims and the value of conjoint and family therapy.

There is a general consensus amongst researchers that prior victimization, especially rape, was associated with higher overall symptomatology and a longer recovery period (Burgess and Holmstrom, 1979; Santiago et al., 1985; Cohen and Roth, 1987). Although 7 patients in this sample had been raped previously, there was no significant association with severity of symptoms or length of stay in hospital. This may be due to the small sample size or the lack of use of standardized instruments. However, prior rape may well be a risk factor for hospitalization but, in the absence of a control group, this cannot be demonstrated.

Economic stress is another variable known to affect the recovery period after rape. This was linked to a longer recovery (Burgess and Holmstrom, 1979) whether due to lower economic status (Cohen and Roth, 1987) or unemployment (Ruch and Leon, 1983). The unemployed in the present study needed a longer period of hospitalization as compared with those employed or scholars (although not of statistical significance), supporting the findings of the researchers mentioned above. The socio-economic status was not documented (a problem in the design of the study) and thus the relationship between socio-economic status and recovery period after rape could not be analysed.

Burgess and Holmstrom (1979) reported that rape victims with a past history of mental health problems took longer to recover from the trauma of rape. It was therefore surprising to find that only two patients in this sample had past mental health problems. This may be related to the small sample size, or because psychotic patients were excluded from the ward programme and thus were treated elsewhere.

The clinical diagnosis was predominantly that of post traumatic stress disorder. This is similar to the findings of other researchers. Breslau et al., (1991) in a random sample of young adults in the Detroit, (Michigan) area of the U.S.A., found that 80% of women who reported that they had been raped had PTSD. Frank and Anderson (1987) in the U.S.A. and Bownes et al. (1991) in Northern Ireland independently found that approximately 70% of recent rape victims met the criteria for PTSD.
In Burge's (1988) sample from the U.S.A., 86% of rape victims were at least moderately affected by symptoms of PTSD. In addition, there was no significant relationship between time since the assault and symptomatology. Thus, all these studies demonstrate that in some victims rape-related symptoms may persist for many years. Treatment approaches should therefore take into account the post traumatic nature of the response to rape.

Treatment of Rape Victims

In the acute crisis situation rape victims need both medical and psychological intervention. Both a medical and gynaecological report are necessary to determine the extent of any injuries sustained and to collect forensic evidence in the event of a court case. The victims also need to be sure that they have not been damaged physically, that they have not been made pregnant and have not been given a venereal disease including human immunodeficiency virus. It is not the task of the physician in the emergency room to determine if the woman has been raped.

The relevant issue is that the woman feels that she has been violated. Although non-psychiatric physicians often do not offer counselling, in centres in the U.S.A. and the U.K. trained counsellors are available 24 hours a day to stay with the victim and offer support (Mccombie et al., 1976; Duddle, 1991). This counsellor offers continued counselling for as long as it is needed.

Initially, the model of crisis-intervention was used in counselling the rape victim (Burgess and Holmstrom, 1974). The post rape symptoms were viewed as a normal response to a crisis in an emotionally healthy woman. Research has indicated however, that a large proportion of women continued to have psychological and sexual problems after rape. These victims tended to reorganise their personalities around the symptoms, conflicts and defenses activated by the trauma (Rose, 1986).

With PTSD being accepted as an alternative conceptualization to rape trauma syndrome, various other treatment models have been proposed.

Psychodynamic psychotherapy has been described in the treatment of rape victims. Loss is the major theme in the psychodynamics and symptomatology of rape victims, and in the responses to the victim by significant others and society. This loss is devastating and intrapsychically, it touches on every stage of psychosexual development as well as affecting sexuality and relationships with others. In each individual, the psychodynamic disturbance is determined by combinations of the nature of the assault, the psychodynamics and past history of the victim, and the response of the environment.

The input of the psychodynamics of the rapist must also be considered (Rose, 1986). Technical problems which occur in the psychodynamic psychotherapy of rape victims are: formation of a therapeutic alliance, identification and interpretation of defences, the victim's conflict over aggression, pre-existing conflicts, countertransferance reactions and contact with social institutions (Rose, 1991).

There are no empirical data available on the outcome of psychotherapy and the factors that determine its appropriateness and effectiveness in this context.

Behaviour Therapy has been better researched. Systematic desensitization (a procedure designed to reduce or eliminate maladaptive anxiety and its behavioural correlates) was compared with Cognitive Behaviour Therapy (a directive time-limited psychotherapy with the emphasis on altering behaviour by changing cognitive processes), in a group of rape victims. There was no significant difference between the two treatments as both were effective in reducing anxiety and depression (Frank et al., 1988).

In a controlled, randomized trial, the efficacy of stress inoculation training [a cognitive behavioural treatment programme adapted by Veronen et al., (1978)], prolonged exposure (using imagery in confronting the rape situation and thus reducing the associated anxiety), and supportive counselling was compared with a waiting-list control group. All treatment conditions produced improvement on all measures immediately after treatment and at follow-up.

However, stress inoculation training produced significantly greater improvement on PTSD symptoms than did supportive counselling or being on the waiting-list immediately following treatment. All follow-up, prolonged exposure produced a superior outcome on PTSD symptoms, followed by those who received stress inoculation training. Patients receiving supportive counselling showed the least improvement. It was suggested that an optimal program should combine both treatments (Foa et al., 1991).

In contrast to the empirical studies, Smith (1991) using two case studies, advocated the use of hypnosis in rape victims whose symptoms persist despite supportive crisis-orientated treatment. He argued that "hypnosis allows a modulated re-experiencing and abreaction of the traumatic event that can help to provide the victims with a relieving sense of mastery". The results of further studies or case reports are awaited before the use of hypnosis in rape victims can be generally advocated.

Group Therapy has also been used in treating rape victims (Xenarios, 1988; Harflett and Scott, 1987). The goals of group therapy were described as follows: "To provide a safe supportive environment of mutual aid so that they can:
(a) understand their reactions to their victimization and
(b) explore the issues and feelings arising from the rape so that they can begin to return to pre-trauma functioning".

The themes that emerged repeatedly were:- vulnerability, fear, guilt, shame, trust, safety, self-esteem and judgement. The groups were able, through the sharing of life stories, to affirm self-worth, encourage self-growth and conclude with a more positive view toward future plans and personal development. There have, to date, been no reports in the literature comparing group therapy with other types of therapy or with a waiting-list control. However, it appears to be a cost-effective method of reaching many rape victims.

The patients in the present sample were all given group therapy; milieu therapy; social skills training; assertiveness training; role play; relaxation therapy and occupational therapy. Certain patients were in addition given family therapy, individual psychodynamic psychotherapy and hypnotherapy, either alone or in combination. The patients responded well to being in group therapy with patients with other problems. Thus, the therapy received was a combination of that advocated in the literature. However, the efficacy of these treatments in an in-patient setting needs to be further researched.

Only three patients needed medication in addition to the therapeutic regimen mentioned above. The indications for medication were:

(1) The presence of psychotic symptoms.

(2) The persistance of PTSD symptoms which incapacitated the patients to such an extent, that they could not function within the therapeutic community.

The remainder were managed using the therapeutic regimen mentioned above. The literature on the drug treatment of rape victims specifically, is sparse and controlled trials non-existent. The populations studied with PTSD have been predominantly Vietnam war veterans. Davidson (1992) in a review of the drug therapy of PTSD had the following recommendations:

a) Pharmacotherapy is most effective when administered as an adjunct to other therapy (group, individual or behavioural psychotherapy).

b) An organic lesion e.g. head injury needs to be excluded before drug therapy is commenced.

c) Patients abusing or dependent on alcohol or other drugs need to be detoxified.

d) A tricyclic antidepressant is the first-choice treatment. Amitriptyline and imipramine are both of proven efficacy and doses of up to 300 mg per day may be required. The side-effects of these tertiary amine tricyclics would justify the early use of a secondary amine drug such as nortriptyline or desipramine. Treatment should continue for at least eight weeks if it is to be adequately evaluated. Fluoxetine or another selective serotonin-reuptake inhibitor is another choice.

e) Second-line treatments include propanolol, clonazepam, lithium or carbamazepine up to therapeutic levels, all of which reduce the hyperarousal and intrusive components of PTSD.

f) A third-line choice is phenelzine or clonidine.

g) Refractory cases may require the combined use of two or more psychotropic drugs.

Long-term treatment of chronic PTSD is usually necessary.

Decisions regarding discontinuation of treatment are based on:

i) degree of symptom remission
ii) progress made in psychotherapy
iii) stability of life situation
iv) presence of on-going stressors
vi) presence or absence of side-effects of the drug

The results of controlled trials evaluating the efficacy of drug treatment of rape victims is thus awaited, but this may not be easy to effect in a medical context.

Rapists

Rapists have been considered to be sexually frustrated men with no sexual outlets. Cohen et al. (1971) suggested that the sexual impulse was the dominating motive and the aggressive aspects of the assault were primarily in the service of the sexual aim. Other researchers (Groth and Burgess, 1977; Burgess and Holmstrom, 1980) disputed this and demonstrated that no offender had to rape for the purpose of sexual gratification. All were either involved in relationships or had access to other sexual outlets.

Another misconception is the myth that rapists are sexually potent. Groth and Burgess (1980) found that 34% of rapists had experienced some type of sexual dysfunction at some point during the rape.

This dysfunction was either erectile inadequacy or ejaculatory incompetence. Only 25% of rapists had clear evidence of no sexual dysfunction during the rape. From rape victim data gathered by the same researchers, half the victims had negative laboratory tests for the presence of sperm.

The legal implications of negative sperm tests are thus extensive, especially as much importance is attached to forensic evidence in securing a conviction.

A Feminist Perspective on Rape - (A Brief Overview)

Feminists see rape as the symbolic enactment of social and cultural attitudes. Metzger (1976) described rape as, "a gross and extreme form of social regulation by which a woman is brutally stripped of her humanity and confronted with her definition as a non-person, a function".

These attitudes have their origins in early history, when womens' main function was considered to be reproduction to ensure the survival of the tribe. When battles were fought, women were raped and seized, along with other bounty. Thus the association between women and property became inextricable. Brownmiller (1976) demonstrated this by quoting Genghis Kahn (who led the thirteenth century Mongol conquest), "A man's highest job in life is to break his enemies, to drive them before him, to take from them all the things that have been theirs, to hear the weeping of those who cherished them, to take their horses between his knees, and to press in his arms the most desirable of their women". He thus expressed the direct connection between manhood, achievement, conquest and rape. Such attitudes were not only a feature of the thirteenth century. A recent report in the local newspaper (Cape Times, 22 January 1993) stated that Serb forces in Yugoslavia had regularly used rape and harassment as part of their campaign to force Muslims and Croats to flee their homes.

In some cases the violations had been carried out in an organised and systematic way, with the deliberate detention of women for rape and sexual abuse.

The above highlights the fact that women are still seen as the property of men. The women were raped to force the men to surrender. Rape was thus used as an act of power and part of the war strategy.

Rape is also seen as an act of power used to control women in the society (Brownmiller, 1976). She argued that rape is "a conscious process of intimidation by which all men keep all women in a state of fear". Women therefore restrict their activities and do not visit friends or venture out at night for walks or entertainment because they fear for their safety.

Our Western cultural value system reinforces male domination over women by the socialization of children and via the media i.e. films, television, pornographic material and children's books (where women are depicted as passive and helpless and men as the powerful leaders).

Male children are socialized to fit the male stereotype (of dominance, forcefulness, independence and strength), whereas female children are socialized to be passive, submissive and in need of economic and emotional dependance on men.

The treatment of rape victims therefore needs to take the above into consideration. Women need to be empowered and take their place as independent and valued members of society.

CONCLUSION

Because of the small number of subjects studied and the non-representative sample, definitive conclusions are inappropriate. A prospective controlled study using standardized instruments would best evaluate the rape victims who require hospitalization and the efficacy of therapy.

Common factors were identified in this group of hospitalized rape victims. These factors included; the youth, unemployment, lack of social support and prior victimization. Young scholars and young unemployed adolescent rape victims appear to be at particularly high risk of symptoms necessitating hospitalization and tend to express their distress by suicidal behaviour. By educating the referral agencies, these patients may be identified earlier and appropriate intervention strategies planned. In addition, the importance of a good supportive network was highlighted, as this not only shortens the period of hospitalization but also tends to protect against the need for rehospitalization. If the supportive network could be mobilized early in the intervention process, the need for hospitalization may be avoided. Of note also was the large number of victims who had been previously raped. This may well be a risk factor for hospitalization and needs to be explored in further prospective research.

The issue regarding the decentralization of Rape Crisis needs to be addressed. If smaller clinics or self-help groups could be established within geographically isolated communities, rape victims may avail themselves of these services and hospitalization may well not be needed.

Prevention strategies also need implementation. Renshaw (1989) advocates that children be given sex and assertiveness education from an early age to protect them from incest and rape. This should start in the home and extend to schools and colleges. Society also needs re-education regarding the effects of sex role stereotypes. Child-rearing practises which reinforce the sex role stereotyping should be challenged. The media, especially television, could serve a valuable role in the education of the public on the effects of rape. Societal myths (previously mentioned) regarding rape should also be challenged (via the media) and hopefully buried.

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APPENDIX 1

Rape History Flowsheet

NAME:
AGE:
MARITAL STATUS:
EMPLOYMENT STATUS:
NUMBER OF ASSAILANTS
STRANGER (i.e. Relation to Rapist)
FEAR:
PAIN:
FORCE:
INJURIES:
WEAPONS:
SHAME:
GUILT:
REPORT OF RAPE:
LEGAL RESULT:
PREGNANT (From Rape)
S.T.D. (Sexually Transmitted Disease)
POST RAPE SYMPTOMS:

A: SOCIAL DETERIORATION
B: PTSD SYMPTOMS
C: ANXIETY
D: DEPRESSION

REFERRED BY:

E: PSYCHIATRIC EMERGENCY AND OUT-PATIENT SERVICES
F: GENERAL HOSPITAL
G: COMMUNITY RESOURCES
H: SOCIAL RESOURCES
I: OTHER

REASON FOR REFERRAL:

J: SOCIAL DETERIORATION
K: RAPE MANAGEMENT
L: SUICIDE RISK
M: REFERRAL AGENCY TREATMENT FAILURE
N: ANXIETY
O: DEPRESSION

TIME BETWEEN RAPE AND HOSPITALIZATION:

MALE RELATIONSHIP NOW:
EMOTIONAL SUPPORT (From Family, Friends):
PARTNER RESPONSE (To Rape):
PAST RAPE:
PAST PSYCHIATRIC HISTORY:

MEDICATION:
NAME OF MEDICATION:
DOSAGE OF MEDICATION:
THERAPY TYPE:

P: MILIEU, GROUP, OCCUPATIONAL THERAPY
Q: FAMILY THERAPY
R: INDIVIDUAL THERAPY
S: HYPNO THERAPY

FOLLOW-UP:

1: PSYCHIATRIC OUT-PATIENT SERVICES
2: COMMUNITY RESOURCES (Rape Crisis; Safeline)
3: SOCIAL RESOURCES (Social Welfare Agencies)
4: OTHER

END DIAGNOSIS:
RE-HOSPITALIZATION:
DURATION OF RE-HOSPITALIZATION:
QUESTIONNAIRE RESPONSE:

APPENDIX 2

NAME:

PRESENTLY EMPLOYED:

MALE RELATIONSHIP NOW:

RESIDUAL RAPE SYMPTOMS:

LIST OF SYMPTOMS:

BENEFIT OF HOSPITALIZATION:

COMMENT ON HOSPITALIZATION:

LEGAL RESULT:

COMMENT ON LEGAL RESULT:

INSIGHTS GAINED (From Treatment):

APPENDIX 3

Record No. 1

F.M., a 23 year old female referred with a history of crying all the time, suicidal ideation, insomnia, nightmares and flashbacks about being raped. She had been raped 5 days before admission to hospital.

She was accosted by 6 men while going home. Initially she tried to fight and shout but the men threatened to harm her. She was raped by all six men. They left her lying on the ground and ran away. She received no support from family or friends. An additional stressor was the lack of accommodation.

She was admitted with the above-mentioned symptoms and received group therapy and occupational therapy. Three weeks after admission she developed perceptual disturbances, thought insertion and withdrawal and thought interference. This was diagnosed as a brief reactive psychosis superimposed on PTSD. There was a good response to trifluoperazine. Once her psychotic symptoms settled, she was given supportive therapy. She was asymptomatic at discharge.

She was readmitted after taking an overdose of prescribed medication. However she failed to return from weekend leave and was lost to follow-up.

Record No. 2

R.B., a 26 year old female referred with a history of irritability, poor concentration, nightmares of being raped and recurrent intrusive recollections of the rape. She was raped 18 days before admission to hospital.

She, along with another woman were the last passengers in a taxi. Instead of being taken home, they were taken to a house where they were assaulted and forced to smoke mandrax mixed with cannabis. Both women were raped repeatedly over four days. She managed to escape on the fifth day.

She received no emotional support from her family. They felt that she was raped because of her own negligence.
She was admitted to the ward with the above-mentioned symptoms. Later it also emerged that she had been raped repeatedly on a deserted beach 6 years before.

She responded well to family therapy, group therapy and occupational therapy and was asymptomatic at discharge.

Record No. 3

S.C., a 23 year old female referred with a history of loss of appetite, insomnia, afraid of being alone, recurrent nightmares of the rape, flashbacks and anxiety. She had been raped 4 weeks prior to admission.

She had accepted a lift from a customer. He drove to a deserted area and raped her repeatedly over a period of four hours. She managed to escape while he stopped at a filling station.

She developed the above-mentioned symptoms after the rape and was admitted to the ward. Her family were unsupportive and felt that she had disgraced them.

She responded well to group therapy, individual and occupational therapy and was asymptomatic at discharge.

She has been readmitted twice after discharge. Both admissions were precipitated by on-going conflict with her family. This continuous conflict had left her feeling unsupported and allowed the rape issues to re-emerge.

At her final discharge she had resolved to move away from her family and had arranged to live with more supportive relatives.

Record No. 4

D.D., a 20 year old female referred with a history of depression, suicidal ideation and a suicidal attempt. These occurred after a colleague tried to harass her sexually. This incident triggered off memories of her rape eleven months previously.

She was raped by a confidence trickster who claimed he knew her father. She let the man into the house. Once inside, he demanded money, ransacked the house and assaulted her. He then cut her clothes from her and raped her on her mother's bed after stuffing her panties into her mouth. Once he had raped her he sliced at her breasts with scissors. After he left the house she released herself and sought help from the neighbour. After the rape her family was unsupportive.

She was admitted to the ward with the above-mentioned symptoms. She responded well to group, individual and family therapy and was asymptomatic at discharge.

She was readmitted 10 months later with a history of depression and suicidal ideation. This was triggered by being unemployed and her not receiving emotional support from her family. After six weeks of treatment, she was asymptomatic and was discharged.

Record No. 5

H.A., a 20 year old female referred with a history of depression irritability, suicidal ideation, inability to concentrate, nightmares and social withdrawal. She had been raped two months prior to admission.

She was with her boyfriend at a deserted spot when they were threatened by 5 men with weapons. Her boyfriend was dragged from the car and the 5 men drove off with her. She was repeatedly raped by all 5 men. One of the rapists dropped her at her friend's house.

She was admitted to the ward with the above-mentioned symptoms which developed after the rape. She was not supported by her boyfriend and felt rejected by him.

She responded well to group and occupational therapy and was asymptomatic at discharge.

Record No. 6

J.J., a 15 year old female was referred with a history of depressive symptoms which occurred after she was raped.

She had been raped over a period of four months by her brother-in-law. She was afraid to inform her family because she feared that the family would be disrupted. However, she became pregnant as a result of the rape. She informed her parents once the pregnancy was diagnosed. Her parents supported her and were very protective of her.

She was refused a therapeutic abortion because she was already in the middle of the second trimester.

She was admitted to the ward with the above-mentioned depressive symptoms. After one week she, in consultation with her family demanded discharge.

When her mother was telephoned to enquire about J.J's progress, she was extremely hostile and refused to have any further contact with the hospital. She also refused to furnish any information about her daughter's pregnancy.

Record No. 7

C.B., a 20 year old female, was referred with a history of two suicidal attempts, on-going suicidal ideation, anxiety, insomnia, persistent thoughts of the rape and isolating herself from others. She had been raped by her boyfriend after she terminated the relationship.

She had known the boyfriend for three months. When she discovered that he was married she decided to terminate the relationship. She informed him of her decision while they were alone in his car. He became angry and then assaulted and raped her before taking her home.

She was unable to continue working as a result of the rape and had to resign. Her family was unsupportive and held her responsible for the rape.

She was admitted to the ward with the above-mentioned symptoms. During hospitalization, it emerged that she had been gang-raped by 15 men 5 years before. She had informed nobody of this ordeal till her admission to hospital.

She had not responded well to group therapy and occupational therapy. Because of the severity of the PTSD symptoms and their non-response to group and occupational therapy, she also received amitriptyline. The response to the combined treatment strategies was good and she was asymptomatic at discharge.

Record No. 8

L.I., a 19 year old female was referred with a history of headaches, insomnia, loss of appetite and decreased energy after being raped four years before admission.

She was raped at the age of 15 by the boyfriend of a friend. He accosted her at a local cafe and dragged her to a deserted empty plot near her home where he raped her. Initially she fought and shouted but later just lay quietly after her clothes were ripped from her body. Once the rapist left, she bathed because she felt dirty. However, the bath did not help to rid her of feeling dirty. She informed nobody of the incident and, as a result received no emotional support from family or friends.

The rape interfered with her ability to concentrate at school, she failed and subsequently left school. Three months prior to admission, she re-experienced the memories of the rape after she became sexually active.

She was admitted to the ward where she presented with the above-mentioned symptoms. Symptoms of PTSD emerged during therapy.

She responded well to group and occupational therapy and was asymptomatic at discharge.

Record No. 9

A.V.W., an 18 year old female was referred with a history of depression and anxiety, after she was raped one year before admission.

She was on her way home when she was accosted by a man pretending to be a detective. He produced a gun, threatened to kill her, and forced her to accompany her to the place where he first accosted her and warned her to be quiet about the rape. However after reporting the rape to the police and identifying the rapist, she received anonymous telephone calls threatening her life.

She developed the above-mentioned symptoms and was admitted to the ward. Complicating her presenting symptoms was her unsupportive family who blamed her for the rape. She had also been raped 4 years previously by a boyfriend.

She responded to group therapy, occupational therapy and hypnotherapy and was asymptomatic at discharge.

She was rehospitalized with symptoms of anxiety and depression but these settled after two weeks of therapy.

Follow-up revealed that she remained asymptomatic after her second discharge. She is employed and copes with her job.

Record No. 10

J.D., a 17 year old female was referred with a history of loss of appetite, insomnia, suicidal ideation and recurrent thoughts about rape. She had been raped 4 days prior to admission.

She was raped by the uncle of a friend in a deserted area covered with bush.

She was admitted to the ward with symptoms of PTSD in addition to the above-mentioned symptoms. She also revealed that she had been previously raped at the age of 12.

In the ward she received group and individual therapy. She was able to explore feelings of guilt, insecurity and anger in therapy.

At discharge she was asuicidal and asymptomatic.

Record No. 11

G.V., an 18 year old female was referred with a history of loss of appetite, insomnia, anxiety, nocturnal screaming spells and flashbacks after she was raped.

She was raped after she and her friends accepted a lift from a stranger after a party. Her friends managed to run away when the intentions of the driver became apparent. She was unable to get away and was repeatedly raped and sodomised. She managed to escape while the rapist was sleeping.

She was admitted to the ward with the above-mentioned symptoms. She also revealed that she had been raped previously.

She worked through the rape experience in group therapy and occupational therapy. She was asymptomatic at discharge.

Follow-up revealed that she had recovered completely, was happy and full of fun and was engaged to be married.

Record No. 12

A.H., a 20 year old female was referred with a history of crying, insomnia, anxiety and suicidal ideation. She had been assaulted and raped by 2 men over a period of 2 days, two weeks before admission.

She was abducted from a full train and taken to a shack where she was raped over 2 days. The two rapists drank alcohol when not raping her and tried to force her to drink the alcohol. On the second day, when both were asleep, she escaped.

She was admitted to the ward with symptoms of PTSD in addition to those mentioned above. She was also found to be pregnant and this was terminated at Groote Schuur Hospital.

She responded well to group therapy, individual and occupational therapy and was asymptomatic at discharge.

Follow-up revealed that she was working well, and appeared to have benefited from hospitalization.

Record No. 13

M.M., an 18 year old female was referred with a history of deterioration in social functioning, nightmares, insomnia, depression and somatic symptoms. She had been raped 18 months prior to admission.

She had been raped by 5 men at a camping site and only informed her parents two months after the rape. She feared that the rapists would carry out their threat to harm her again.

She was unable to complete her secretarial course because of recurrent memories of the rape interfering with her concentration.

She was admitted to the ward with the above-mentioned symptoms. She responded well to group therapy, occupational therapy and hypnotherapy.

At discharge she was asymptomatic.

She was well at follow-up and her father reported that she was socializing, had a boyfriend and had completed a computer course.

Record No. 14

M.B., a 25 year old female was referred with a history of two suicidal attempts and symptoms of depression and nightmares following a gang rape.

Three years prior to admission, she was raped by 9 masked men at a beachfront. After all had raped her, they discussed killing her but decided against it and abandoned her at the beach. She crawled to the road and a passing motorist helped her.

She became pregnant as a result of the rape and initially thought of abortion or adoption but then lost interest. She had the baby but continued to feel anger, guilt and socially isolated. Her mother who was unsupportive from the time she was informed of the rape, was found dead in a bush one week after the birth of the baby.

She was admitted to the ward and underlying precipitants were:

1. constant letters and anonymous telephone calls threatening her life and reminding her of the rape
2. unsupportive family
3. financial stressors

She responded well to group therapy and occupational therapy and was asymptomatic on discharge.

She was readmitted following a re-emergence of PTSD symptoms following conflict with a new boyfriend and on-going financial stressors. The focus of therapy was the crisis precipitating the admission. She was discharged after a short period of hospitalization.

Record No. 15

R.C., an 18 year old female was referred with a history of loss of appetite, being tearful and refusing to speak to anybody. She had made a suicide attempt by overdosing on medication. She had been raped 10 days previously.

She had been raped by 3 men who were familiar to her and was rescued by 2 people passing by.

She was admitted to the ward with the above-mentioned symptoms. Her symptoms were exacerbated by her boyfriend's non-support and ultimate rejection of her after the rape. During her stay, symptoms of PTSD emerged.

She responded well to group therapy and occupational therapy and at discharge, was asymptomatic.

Record No. 16

E.S., an 18 year old female was referred with a history of nightmares, feeling suicidal and feeling isolated and without a future after she was raped by 23 men.

She was raped by 23 men after returning from a dance at midnight. After all had raped her, one of the rapists took her to an outside room where he continued to rape her. She was rescued the next day by a friend. When her mother was informed of the rape, she was unsupportive, blamed her for what had happened and almost evicted her from the home.

She was admitted to the ward with the above-mentioned symptoms. She received group therapy, individual therapy and occupational therapy. She had difficulty in working through her rape experience. This was further complicated by a non-supportive, conflictual relationship with her parents and the threat of loss of her job. Her family also refused to be involved in her treatment.

She failed to return to the ward after weekend leave and attempts to contact her were unsuccessful. At the time of her leaving the ward, she was no longer suicidal and had worked through aspect of the rape.

Record No. 17

E.A., an 18 year old female was referred with a history of depression after being raped 12 days prior to admission.

She was raped by the subdeacon of her church. The subdeacon lured her to his house on the pretext that she had to telephone her friend. Once there, he offered her a beer and put his arm around her. When she became angry and wanted to leave, he locked her in the house, physically assaulted her and raped her after threatening to kill her with a knife. She escaped after the rapist fell asleep and she then sought refuge at another priest's house. She was taken home and her mother was informed of the rape.

She was admitted with symptoms of depression. later, however, additional symptoms of PTSD emerged. She responded well to group and occupational therapy, and was asymptomatic on discharge.

Record No. 18

E.L., a 22 year old female was referred with a history of decreased concentration, forgetfulness and flashbacks and nightmares about rape. These symptoms occurred following a physical assault 8 months prior to admission.

The above-mentioned assault triggered memories of a rape experience 2 years prior to admission. She had been assaulted and raped and was unconscious for a few hours. This experience resulted in anxiety and somatic symptoms. There was also an impairment in occupational functioning resulting in her demotion with a drop in salary. She had strong feelings of guilt about being raped and was thus unable to inform her family of her rape experience. The family were thus unsupportive.

She responded well to group and occupational therapy and was able to come to terms with both the rape experience and the assault. At discharge, she was asymptomatic.

Record No. 19

F.B., a 16 year old female was referred with a history of low self-esteem, impaired concentration, insomnia and nightmares and a deterioration in occupational functioning. These symptoms occurred after she was gang-raped three times in one week.

She was gang-raped by a previous boyfriend and his three friends. They threatened to hurt her family and burn her house down if she informed anybody of the rape. She was intimidated by these threats and feared for her own life and the safety of her family.

She was rescued from the rapists (after the third rape) when a security guard saw her being assaulted. Only then was she able to lay a charge with the police. She also informed her family. They were unsupportive and held her responsible for the rape.

Six weeks after the rape she was admitted to the ward. She received group therapy, occupational therapy and hypnotherapy and responded well. She was asymptomatic on discharge.

Record No. 20

J.B., an 18 year old female, was referred with a history of suicidal ideation, two suicidal attempts, feelings of depression, recurrent nightmares and flashbacks, fear of being alone, phobic avoidance and feelings of detachment.

Fifteen months prior to admission she was raped by her parish priest while alone at his home. She informed nobody of the incident but, 6 months later, felt suicidal and received psychotherapy as an out-patient. She did not reveal the rape to her therapist.

She became sexually active 3 months prior to admission. She suspected she was pregnant and informed her mother and her boyfriend. They were unsupportive and she then slashed her wrists as she felt abandoned.

This suicidal gesture precipitated her admission to hospital. Her behaviour was characterised by acting out behaviour i.e. suicidal gestures and absconding from the ward. After 8 weeks of therapy, she revealed that she had been raped previously and had not informed anybody of this.

She received group, individual, family and hypnotherapy. She also received amitriptyline. At discharge she was able to integrated some aspects of the rape experience but remained disillusioned and angry.

APPENDIX 4

Letter written by Patient 3

although I know that he must be here because he needs help, I feel that my privacy was taken away. He is intruding. I felt safe among the women. I feel unsafe in my mind although I know that he can't touch me. I stayed in my room the whole day because I did not want to see him. I did not even have lunch or supper because I felt safe in my room. I feel like screaming, crying because I can't do anything to get away from this feeling of hate. I know that I must start to trust people but I do not think that it is possible. I feel angry and unhappy - what is happening? I am not the same anymore - I never used to hate people - Sometimes I even think of getting someone to kill Desmond for me so that I can get on with my life.

Will I ever be able to go on with my life? - I don't even care how I look or what other people say or do - I just feel like ending it all. I ask myself: 'Will I be able to go to court and give a statement? - What if he looks at me again and smiles? - will I be able to handle it?' - He destroyed my whole life - What if he's found not guilty? - Can I handle that? - What will happen within three to five years? - Will I still have the same feelings? - "Will the nightmares stop? Will the guilty feeling that I have ever go away? Will I ever be myself again? - Will I ever be able to use public transport again? - Do my own shopping without being scared? I don't even think that I do have a future". Why did I come for help? If I feel like ending it all - I must get relaxing therapy because I am nervous - Why? - I am scared to sleep - Sometimes I feel so empty that I get scared. I cry every day because I feel that I do not get answers. I am back at the hospital but I don't think that they can help me. Why do they keep me here? Sometimes I think I am mad because I think what if he's found guilty? - What will his family do? - I know that I can't change the past - is there a future?

Letter written by Patient 4

I weep every day because I am mourning. The reason why I am using this expression is because I have died and lost myself mentally. The person that I used to be and what I turned out to be differs like night and day. Let me give you an insight of the Dulecia of the past.

I was an extrovert, happy go lucky and slow to anger. I was well known not only by my friends and youngsters but also amongst grown ups and the older people.

I looked at life with a positive eye and mind. I could take failure and success and believed in myself. I had great trust in my neighbour and strangers and always saw the good rather than the bad in other people.

"My experience in life had shattered my whole self-image. My trust turned into distrust and my love and caring attitude turned into hatred. My self-confidence turned into uncertainty and I am feeling scared and afraid of what the future might hold in store for me, that's if there is a future in this dark cruel world for me at all".

Letter written by Patient 16

Dear Staff

You all might think that I don't want to show my feelings or express it. Its' one of the hardest things for me to do. Now I know it's no use pretending. At least I admit to myself. The reason for writing is because this was always my way of expressing my feelings. I really want to learn how to express myself. I feel guilty cause everyone can do it but not me. And I feel as if I'm, wasting all your time. The only thing that's very hard for me to say is what I went through on the 13/1/90. As I am writing this letter I feel hurt and really bad. Every day I keep on thinking it's better to die than to go through these feelings. "There are certain feelings which I don't understand but I know those are the feelings that put me down.

I wish I can escape this cause one thing I know is that a knife wound won't hurt so bad as this hurt. At this very moment I feel like screaming. I'm frustrated. Each time I ask myself 'Why me?' And you know what's hurting me really - that's one thing I keep on saying to myself, one thing, that's hard for whether I'm right or wrong. I BLAME MYSELF.

Because if only I could defend myself maybe killed myself the time I told him I was going to. But I couldn't. I was so scared, afraid and hurt.

All I ask if I'm doing the right thing to write. And please assist me in this.

I don't think I can make it on the 28/1/90.